WORK ACTIVITY REPORT

This report is for:	
Month	Year

You may be considered disabled for Medi-Cal if you cannot do any kind of work for which you are suited, and only if you cannot work for at least a year or your condition will result in death.

If your gross earnings are more than $_____ *(current SGA amount)* per month, you might not be considered disabled. Work expenses and special work considerations related to your disability may be deducted in figuring whether your earnings meet the earnings limit. For this reason, information about your work activity is needed.

The information you provide about your work activity will be used in making a decision on your case. Your employer may be contacted to verify the information you provide.

Name of disabled person			Social security number	
Employer's name			Employer's telephone number ( )	
Employer's address (number, street)	City		State	ZIP Code
Title or name of your job	Rate of pay	Hours worked per week	Dates worked (month/year) From: _____ To: _____	
Employer's name			Employer's telephone number ( )	
Employer's address (number, street)	City		State	ZIP Code
Title or name of your job	Rate of pay	Hours worked per week	Dates worked (month/year) From: _____ To: _____	

1. **Gross Earning**—What is your gross monthly pay? (If pay is irregular, you do not need to enter the amount.) Attach your pay stubs.

2. **Other Payments**—Specify other payments you receive, such as tips, free meals, room, or utilities. Indicate what you were given and estimate the dollar value and how frequently you receive them.

3. **Special Employment Situations**

	Yes	No
After you became ill, did your job duties lessen?	❒	❒
If yes, did you get to keep your same pay?	❒	❒
Are you employed by a friend or relative?	❒	❒
Are you in a special training or rehabilitation program?	❒	❒

4. **Job Requirements**—Are your job duties listed below different from those of other workers with the same job title?

	Yes	No
a. Shorter hours	❒	❒
b. Different pay scale	❒	❒
c. Less or easier duties	❒	❒
d. Extra help given	❒	❒
e. Lower production	❒	❒
f. Lower quality	❒	❒
g. Other differences (e.g., frequent absences)	❒	❒

5. **Explanation of Job Requirements**—Describe all "yes" answers in item 4 on page 1.

6. **Special Work Expenses**—Specify below any special expenses related to your condition which are necessary for you to work. These are things which you paid for and not things that will be paid for by anyone else.

   Specify the amount of the expenses. Attach verification of who prescribed the item or service needed and the cost paid. (We are required to verify the need for the item or service with the person who prescribed it.)

   Example: Attendant care services, transportation costs, medical devices, work-related equipment, prosthesis, modifications to your home, routine drugs and medical services necessary to control a disabling condition, diagnostic procedures, assistants (e.g., if visually impaired, the cost to hire a reader; if hearing impaired, the cost to hire a sign language interpreter), or similar items or services.

   _____

   _____

7. **Subsidies**—Some employers will support disabled individuals with subsidies. For example, the employer may subsidize the disabled employee's earnings by paying more in wages than the reasonable value of the actual work that was done. (For example, many sheltered work centers subsidize an individual's earnings.)

   Does your employer provide you with subsidies? ❒ Yes ❒ No

   If yes, please (a) tell us how much the subsidy is worth and (b) explain the type of subsidy that was given.

   a. $_____

   b. Explanation of subsidy: _____

   _____

   _____

8. Use this additional space to answer any previous questions or to give additional information that you think will be helpful.

   _____

   _____

   _____

   _____

9. Please read the following statement. Sign and date the form. Provide address and telephone number.

   If my employer should need to be contacted, this also authorizes my employer to disclose any information necessary for the county to evaluate my work activity for my Medi-Cal application based on disability.

   I have completed this form correctly and truthfully to the best of my knowledge and abilities.

Signature of applicant or representative	Date	Area code and telephone number ( )

Mailing address (number, street, apartment number, P.O. box number, or Rural Route)

City	County	State	ZIP code

CHECKLIST FOR COUNTY USE ONLY

1. Enter amount of client's gross wages. $_____
   Does the client have any of the following deductions?
   a. Subsidy (see MEPM, Article 22, 22C-2.7) ❒ Yes ❒ No If yes, enter amount: $_____
   b. Impairment-related work expenses (IRWEs) ❒ Yes ❒ No If yes, enter amount: $_____
2. Add a and b above and subtract total from number 1. Is the remainder over the current SGA amount? ❒ Yes ❒ No
   If yes, client is engaging in SGA. If any explanations are needed, please use the following space:

_____

_____

_____

Eligibility Worker signature	Worker number	Date completed